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ABSTRACT

Some states have established community-based forensic services, such as competency and sanity evaluation programs. Since changing from inpatient, centralized evaluations to community-based, decentralized evaluations may result in lower costs, a study was conducted to examine the feasibility of doing more forensic sanity and competency evaluations and treatment on an outpatient basis in Colorado. A feasibility questionnaire was given to 288 community mental health center and state hospital administrators and treatment staff members. The respondents indicated that, given enhanced community evaluation and treatment programs for forensic clients, 41% of the sanity evaluations and 45% of the competency evaluations done at the hospital could be done in local communities, 35% to 38% of the clients found incompetent could be treated in local communities, and 39% to 50% of the clients found insane could be released to outpatient treatment 6 months earlier than is currently the case. Other findings indicated several specific improvements needed in the community mental health system before it could properly handle more forensic clients. Major concerns dealt with adequacy of staff training for working with incompetent and insane clients, liability exposure, and time spent waiting for hearings and for release from state hospitals. (KS)

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Incompetency and Insanity:

Feasibility of Community Evaluation and Treatment

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Abstract

In order to examine the feasibility of doing more sanity and competency evaluations and treatment on an outpatient basis rather than at a state hosital, we gave a feasibility questionnaire to 288 CMHC and state hospital administrators and treatment staff members. The respondents indicated that, given enhanced community evaluation and treatment programs for forensic clients, (a) 41% of the sanity evaluations and 45% of the competency evaluations done at the hospital could be done in local communities, (b) 35% to 38% of the clients found incompetent could be treated in local communities, and (c) 39% to 50% of the clients found insane could be released to outpatient treatment six months earlier than presently. Other findings indicated several specific improvements needed in the community mental health system before it can properly handle more forensic clients.

Incompetency and Insanity: Feasibility of Community Evaluation and Treatment

Introduction

The purpose of this research project was to examine the feasibility of providing more forensic services on an outpatient basis in Colorado. The major issues we addressed were (a) the types of forensic clients at the Colorado State Hospital who may be appropriate for community evaluation or treatment, and (b) the features that would be required of a successful community forensic program.

For the purposes of our project, we used three categories of forensic clients: individuals undergoing a sanity or competency evaluation, individuals who have been found incompetent to proceed, and individuals who have been found not guilty by reason of insanity.

Individuals undergoing competency evaluations have criminal charges pending and are being evaluated to determine whether they understand the charges brought against them and can asssist in their own defense. Individuals undergoing sanity evaluations have criminal charges pending and are being evaluated to determine if they were sane at the time they committed the crime.

One hundred and forty-eight court ordered competency evaluations and 47 court ordered sanity evaluations were completed at Colorado State Hospital in the fiscal year 85/86, with an average stay at CSH of approximately 28 days for each.

Several states have recently established community based or quasi-community based competency and sanity evaluation programs,

including Connecticut (Fitzgerald, Peszke, and Goodwin, 1978), Massachusetts (Schreiber, 1982), Michigan (C. R. Clark, personal communication, August 1, 1986), Ohio (Beran & Toomey, 1979), Tennesee (Laben, Kashgarian, Nessa, & Spencer, 1977) and Virginia (Melton, Weithorn, & Slobogin, 1985).

A major potential advantage of changing from inpatient, centralized evaluations to community based, decentralized evaluations is the lower cost of the community based evaluations. Savings of 40% to 67% have been reported in Tennesee (Laben, et al., 1977), Connecticut (Fitzgerald, et al., 1978), and Virginia (Melton, et al., 1985).

Melton, et al. (1985) showed that evaluation reports written by community evaluators were highly thought of by the legal community and forensic experts. Beran and Toomey (1979) also reported a positive reaction from the legal community towards reports written in the community based centers in Ohio.

Other possible advantages of community based evaluation systems over centralized inpatient evaluation systems include avoiding bail denial, aiding the right to a speedy trial (Roesch & Golding, 1980), avoiding the stigma of hospitalization, and avoiding difficulty in trial preparation because of the physical separation of attorney and client (Melton, et al., 1985).

Individuals who have been found incompetent to proceed have been charged with a crime and have been found unable to assist in their own defense or unable to understand the charges brought against them. These individuals must be restored to competency before legal proceedings against them can continue.

The Colorado State Hospital (CSH) completed treatment of 90 individuals who had been found incompetent during the fiscal year 85/86. Individuals found incompetent stayed an average of 147 days at the CSH, 33 days of which were spent waiting to return to court for a competency hearing after the hospital concluded they had become competent again.

Our literature review produced no indication of a move in other states to do more treatment of incompetent clients in local communities.

Individuals found not guilty by reason of insanity are those found not guilty of a crime because they were mentally ill at the time of the crime and therefore unable to conform their behavior to the law. In Colorado these individuals must be committed to the State Hospital before being eligible for community placement. A court hearing determines when a client becomes eligible for community placement in the form of conditional release. Generally the court grants conditional release after the forensics disposition committee at CSH has decided that the client is ready for placement in the community. If clients violate the conditions of their conditional release, they may be sent back to CSH. The most recent CSH statistics indicate that clients committed for insanity stay at the CSH an average of eight years.

Our literature review provided no evidence of a move in other states to decrease the amount of time such individuals spend in a state hosptal before being released to outpatient treatment.

Method

Subjects and Sampling

The sample consisted of 145 staff members of the Colorado State Hospital (CSH) and 143 staff members of 19 Colorado CMHCs. THe CSH staff members were randomly selected from forensic clinical staff, except that all forensic adminstrators were selected. The CMHC subjects were randomly selected from the 19 CMHCs that agreed to participate in the project. Only one center refused to participate. The subjects were randomly selected, except that the director and forensic coordinator for each center was selected.

Questionnaire

On the basis of the literature review and 10 key informant interviews of CSH and CMHC administrators and staff, we constructed a questionnaire that asked specific questions about current forensic inpatients and possible outpatient services for them. We then created nine different versions of the questionnaire so that various subgroups of subjects were asked only questions within their areas of experience. For instance, CMHC directors were asked about their concern over civil liability if there centers were to do more forensic work, and CSH staff were asked about what percentage of certain types of forensic inpatients could be evaluated as outpatients.

We delivered the questionnaires to the selected subjects along with a cover letter explaining the project to subjects. The researchers gave subjects reminder slips if they had not returned their questionnaires by the deadline given in the cover

letter. To insure confidentiality, all subjects' names were written on the cover letter, which was detached by the subject and returned separately from the questionnaire.

Results

Of the 145 questionnaires given to state hosital (CSH) staff members 76 (52%) were returned. Of the 143 questionnaires given to CMHC staff members 112 (78%) were returned. The relatively low participation rate at the CSH may have been due to the recent closing of a CSH ward. Through informal conversation with CSH staff members the researchers learned that many of the staff members were upset by the closing of the ward. One staff member mentioned that some individuals who were asked to participate in the study thought that the study was part of a move to close further wards.

Forty staff members at CSH who deal with evaluation clients answered a question about what percentage of clients now being evaluated at CSH could be evaluated in jail were there an enhanced community program. Their overall response indicated that 45% of the competency evaluations now done at CSH could be done in jail and that 41% of the sanity evaluations now done at CSH could be done in jail.

CSH administrators and CMHC directors were asked whether it would be helpful to require licensing and registration of individuals doing outpatient evaluations. Fifteen out of 22 believed licensing and registration requirements would be helpful. The administrators and directors were also asked whether it would be helpful to require continuing education of

individuals doing outpatient evalustions. Eighteen out of 22 believed continuing education requirements would be helpful.

Ninety-eight CMHC treatment staff members (including forensic coordinators) answered a question about how adequate their training was for doing competency and sanity screenings and evaluations. On a scale of five, on which 1 was not adequate and 5 was very adequate, treatment staff members had an average response of 2.14 for doing competency evaluations, and an average response of 2.02 for doing sanity evaluations.

The 98 CMHC treatment staff members plus 40 treatment staff members from CSH who deal with evaluation clients answered a question about what training would be helpful for people doing evaluations in the community. Each of the three types of training suggested, assessments done for evaluations, report writing done for the court, and law relating to competency and sanity evaluations was given average ratings of 4.05 or greater on a scale on which 5 was very helpful and 1 was not helpful.

Fourteen CMHC directors answered a question about how concerned they would be about additional liability exposure were their center to do more competency and sanity screenings and evaluations. On a five-point scale, on which 1 was not concerned and 5 was very concerned, their average response was 4.14 for doing competency evaluations and 4.50 for doing sanity evaluations.

Forty-eight staff members from CSH who deal with individuals found incompetent answered questions about what percentage of clients presently treated at CSH could be treated in the

community and what percentage could be treated in jail were there enhanced community or jail treatment programs. The respondents thought that, given enhancement, 35 % could be treated in the community and that 38 % could be treated in jail. The two percentages were not necessarily cumulative.

We asked the CMHC treatment staff members (including forensic coordinators) how adequate they felt their training was for working with ITP clients in jail and in the community. The 98 respondents had an average response of 2.32 for treating ITP clients in jail and an average response of 2.59 for treating ITP clients in the community on a five-point scale on which 1 was not adequate and 5 was very adequate.

The 98 CMHC treatment staff members plus the 48 treatment staff members from CSH who deal with incompetent clients answered a question about what training would be helpful for people working with incompetent clients in the community. Each of the three types of training suggested, learning about treatments used to restore competency, report writing done for the court, and law relating to competency, received average ratings of 3.97 or greater on a scale on which 5 was very helpful and 1 was not helpful.

CMHC directors were asked how concerned they would be about additional liability exposure were their center to work more with incompetent clients in jail or in the community. The average response of the 14 respondents was 4.07 for working with incompetent clients in jail and 4.50 for working with incompetent clients in the community on a five-point scale on which a 1 was not concerned and a 5 was very concerned.

CSH administrators were asked what might be done about the average 30 day wait in the hospital clients found incompetent have the hospital decides they have been restored to competency. The delay occurs because clients are kept in the state hospital until a court hearing is held on whether they have regained competency. Six of the eight administrators believed that these clients should be discharged to jail or the community immediately after the hospital offers the opinion that they are competent.

Seventy-six CMHC and CSH staff members who deal with individuals found not guilty by reason of insanity reponded to a question about how many individuals being confined to the state hosptial for insanity could be released sooned. As a group, the respondents indicated that, if there were transition residences, 50% of the individuals confined to the hospital for insanity could be released conditionally six months earlier. If there were an enhanced compliance monitoring system, 39 % of these x clients could be released six months earlier. If there were an intensive advocate case management system, 45 % could be released earlier. In this type of system the case manager assists clients in obaining housing, employment, financial assistance and othe important elements of life.

CMHC staff members and forensic coordinators were asked how adequate they felt their training is for working with insane individuals on conditional release. Treatment staff members had an average response of 2.51 on a five-point scale on which 1 was not adequate and 5 was very adequate. Forensic coordinators had an average response of 3.39 on the same five-point scale.

CMHC directors were also asked how concerned they would be about additional liability exposure were their center to work more with clients who have been found insane. Their average response was 4.64 on a five-point scale on which a 1 was not concerned and a 5 was very concerned.

Conclusions

The chief finding of this project was that there appear to be a large number of forensic inpatients at the Colorado State Hospital who could be evaluated or treated as outpatients in their home communities were there an enhanced outpatient program for them. The state hospital questionnaire respondents estimated as a group that 45% of the competency evaluations and 41% of the sanity evaluations now done annually at the hospital could be done in jail were there an enhanced community evaluation system.

The state hospital respondents estimated as a group that 38% of the individuals now treated at the hospital for incompetency could be treated in jail and that 35% could be treated in the community were there an enhnced treatment system. Finally, the respndents who worked with insane individuals estimated that 50% or so could be released six months sooner if there were additional community services for them, such as transition residences, compliance monitoring or community support.

These findings suggest that it is time for Colorado to attempt to have more forensic evaluation and treatment done on an

outpatient basis. Cost savings could be substantial, and unnecessary confinement could be eliminated for many individuals who have never been convicted of a crime.

Other important findings relevant to both forensic evaluation and treatment were that the CMHC respondents tended to doubt the adequacy of their training for evaluating and treating more forensic clients, and that the CMHC directors expressed great concern about additional liability exposure if their centers began doing more forensic work.

These findings suggest that extensive training in forensic work and liability management would be necessary before the outpatient mental health system could provide more forensic outpatient services. Further, the funding for extra forensic work might have to include money for additional insurance costs, as well as for training and service costs.

CSH and CMHC administrators tended to state that certification and continuing education requirements for outpatient evaluators would be helpful. CSH and CMHC staff members recommended that CMHC staff who do communitiy evaluations and treatment first receive training in forensic assessment, the law relating to competency and insanity, and report writing done for the courts.

These findings make a good deal of sense and should be followed in enhancing the community mental healh system enough to allow more forensic evaluations to be done on an outpatient basis in local communities.

The majority of administrators at the CSH believed that clients should be discharged immediately after CSH has found them to have regained competency. This might be accomplished by court

commitment orders that allow discharge to outpatient or jail treatment, pending a hearing, once the CSH has concluded that a defendant has regained competency. Expensive state hospital care could then be focused on only those individuals who need it.

One sensible approach for Colorado to take at this point would be to arrange one or two demonstration projects in limited areas of the state and then determine the actual costs and benefits of outpatient forensic evaluation and treatment in these areas. Once that information is collected, decisions could be made about whether to change the current method of providing these services.

It would be useful in demonstration projects or otherwise to develop empirally based methods of determining which clients can and cannot be evaluated or treated on an outpatient basis. It would also be useful to determine empirically whether outpatient treatment is more or less effective than inpatient treatment.

The findings and conclusions of this study suggest that states other than Colorado might appropriately examine their inpatient forensic services to determine which, if any, could be provided on an outpatient, community centered basis.

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